

The Gist-Brocades Travelling Fellowship, 1990

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In 1990, Gist-Brocades inaugurated a travelling fellowship to allow doctors training in genitourinary medicine to travel abroad for study or research. I was awarded the fellowship in 1990 for the purpose of studying outreach intervention in Amsterdam and considering how this could be used as a model for genitourinary medicine services in Britain.

Why Amsterdam?

I chose Amsterdam as a learning model for outreach intervention for several reasons. Its intervention measures have been:—

- (1) *Early:* Methadone buses were introduced as early as 1979, as part of the integrated drugs policy.
- (2) *Flexible:* Outreach measures were repeatedly modified, particularly in response to the HIV epidemic.
- (3) *Effective:* Both needle sharing behaviour and total consumption of "hard drugs" have declined in the city since introduction of outreach intervention. 60–80% of Amsterdam's hard drug using population is now in contact with treatment services.
- (4) *Innovative:* An example is the unique Methadone buses. Amsterdam was an early proponent of the harm minimisation model and introduced needle exchanges as early as 1984.
- (5) *Integrated:* Neighbourhood organisations, police, helping services, health education planners and drug users' associations ("Junkiebonden") all contribute to a coordinated and effective drug policy.
- (6) *Well evaluated and researched.*

Components of study visit

I spent two weeks in Amsterdam in November 1990 and divided my visit into four main areas, further described below.

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(1) STD Clinic, Groenburgwal

Amsterdam, with a city population of 700,000, has one municipal STD clinic run by the GGGD (Municipal Health Service) which, in 1989, saw 14,097 new patients (8,465 males, 18% of whom were homosexual or bisexual; 5,632 females, 32% of whom were working as prostitutes). The clinic is staffed by one full time consultant dermatovenereologist, two trainee dermatovenereologists and a number of clinical assistants. The 10 nurses see and examine all patients by clinic protocol, calling doctors for advice when necessary. The clinic protocol is designed strictly for STD screening. (Cervical cytology and hepatitis B vaccination, for example, are not offered). The nurses also perform all the clerical duties, aided by computerised data collection. Two laboratory technicians provide a microscopy service. Five social nurses (the equivalent of health advisers) run their own HIV counselling and testing sessions three times per week. The clinic is open daily, morning sessions operating on a "no-appointment" basis; in the afternoons patients are seen by appointment only.

The STD clinic provides a number of services for drug users and prostitutes. One of the social nurses specialises in outreach work for prostitutes, targeting particularly those in ethnic minorities. A weekly evening clinic for drug addicted prostitutes cares for a cohort of 250 patients, who are seen on average every four months. Most are working as street prostitutes. The clinic also contributes to an outreach project, known as the "Huiskamer" (living room) project, near central station. This night shelter caters mainly for street prostitutes. A doctor and social nurse run one weekly evening clinic there, offering advice, condoms and referral to existing STD and HIV services. I also had an interesting visit to a brothel with one of the clinic doctors, who ran an outreach clinic there.

(2) Sociological research on prostitution

The De Graaf Stichting is a foundation for sociological research on prostitution which advises on state policy concerning prostitution. One current debate in the Netherlands concerns legalisation of prostitution. Legalisation would improve working conditions and legislative protection for prostitutes. However, 60% of prostitutes in Amsterdam are non-Dutch nationals, many with no legal status in the Netherlands; registration schemes would drive many

prostitutes “underground”, making health care access for this vulnerable group extremely difficult.

The foundation is also engaged in fascinating research on the negotiating processes between customers and prostitutes and the resulting sexual networks, which may have direct relevance to the epidemiology of HIV infection.

(3) Municipal drugs team

The GGGD drugs team functions on a strong outreach network. It runs two methadone buses each of which visits six urban locations daily to offer methadone, condoms, needle exchange facilities, basic health care and rehabilitation referral when appropriate. The drugs team also runs three community clinics along similar lines. A network of field workers visits city police stations daily (2000 contacts are made with drug users every year by this route), leading to rehabilitation services which are likely to be more appropriate than criminal proceedings.

(4) Public health policy-making on outreach

During my visit I visited several government agencies which are responsible for planning both national and local policy on outreach work. Outreach is viewed as a fundamental element of services to sex industry workers. Successful projects (running in Amsterdam, Rotterdam, the Hague, Utrecht and Alkmaar) are those which are attractive to use and offer useful practical services to their users (ranging from a simple chat over a cup of coffee to legal and welfare advice), in addition to basic STD screening.

The government is aware of the need to target adolescents, one Dutch survey of 700 school children aged 16 and 17 having shown that 50% were sexually active. Videos and leaflets are issued in schools, youth clubs and cafés. The GGGD employs one full time field worker outreaching male prostitutes; there are estimated to be approximately 350 “rent boys” in Amsterdam, a quarter of whom are working on streets or in stations and 3/4 in brothels and bars. Gay men’s groups are also actively promoting “safer sex” to this group, offering condoms and health education, using role play in assertiveness training.

Relevance of the Amsterdam model to Britain

Impressive as the Amsterdam model of outreach intervention is, it is clearly inappropriate to extrapolate directly to Britain’s different cultural and political environment. However, there are several aspects of public health HIV policy from which we can learn. Services in Amsterdam are impressively well coordinated and evaluated, flexible and readily modified. Experience gained in Amsterdam has led to development of two initiatives in Bloomsbury Health District in London. A successful satellite genitourinary medicine clinic for sex industry workers in Soho has been in existence since December 1990; a “drop-in” centre for female sex industry workers in the Kings Cross area of London, similar to the “Huiskamer” project in Amsterdam, is also expected to begin operation in the near future.